STATE LOAN REPAYMENT PROGRAM (SLRP/MLARP)

APPLICATION DEADLINE: April 15, 2015

PART II: PRACTICE SITE CONFIRMATION

Name: _____ Date of Birth: _____

I authorize my employer, _____, to provide the information requested by the Maryland Higher Education Commission, Office of Student Financial Assistance.

Candidate's Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY YOUR EMPLOYER

Practitioner is an (check one): _____MD/DO _____Physician Assistant _____Medical Resident

Practice Specialty: _____ Date Employment Began: _____ Annual Salary: _____

MD/DO/PA

1. Will the practitioner work at least 40 hours (full-time) per week, excluding time spent "on call?" ☐ Yes ☐ No

   If **No**, please explain: _____

   _____

2. Will the practitioner provide at least 32 of the 40 normally scheduled office hours per week in an ambulatory (outpatient) setting?

   ☐ Yes ☐ No If **No,** please explain: _____

   _____

3. Will the practitioner's 40-hour work week be compressed into less than 4 days per week or with shifts of more than 12 hours in any 24-hour period?

   ☐ Yes ☐ No If **Yes**, please explain: _____

   _____

4. Has/Will the practitioner spent/spend more than 7 weeks (35 days) away from the practice for holidays, vacation, continuing professional education, illness or any other reason during a 52-week time period?

   ☐ Yes ☐ No If **Yes**, please explain: _____

   _____

Medical Resident

5. I am enrolled full time as a medical resident specializing in primary care. ☐ Yes ☐ No

I certify that the information provided above is true and correct.

_____ _____

Printed name of person completing this form Signature of person completing this form

Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

E-Mail: _____

PLEASE MAIL TO:

Temi Oshiyoye, Workforce Coordinator, Attn: SLRP/MLARP Application
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